SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT SUBMISSIONS

1. Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.

The Patient Protection and Affordable Care Act, Public Law 111-148, (the Affordable Care Act) was enacted by President Obama on March 23, 2010. As part of the Act, Congress added Public Health Service Act (the PHS Act) section 2719, which provides rules relating to internal claims and appeals and external review processes. The Departments issued interim final regulations on July 23, 2010 (75 FR 43330) that set forth rules implementing PHS Act section 2719 for internal claims and appeals and external review processes. With respect to internal claims and appeals processes for group health coverage, PHS Act section 2719 and paragraph (b)(2)(i) of the interim final regulations provide that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503-1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor in paragraph (b)(2)(ii) of the regulations.

The DOL claims procedure regulation requires plans to provide every claimant who is denied a claim with a written or electronic notice that contains the specific reasons for denial, a reference to the relevant plan provisions on which the denial is based, a description of any additional information necessary to perfect the claim, and a description of steps to be taken if the participant or beneficiary wishes to appeal the denial. The regulation also requires that any adverse decision upon review be in writing (including electronic means) and include specific reasons for the decision, as well as references to relevant plan provisions. Paragraph (b)(2)(ii)(C) of the interim final regulations adds an additional requirement that non-grandfathered ERISA-covered group health plans provide to the claimant, free of charge, any new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim.[1]

1 Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Also, PHS Act section 2719 and the interim final regulations provide that group health plans and issuers offering group health insurance coverage must comply either with a State external review process or a Federal review process. The regulations provide a basis for determining when plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process.

The claims procedure regulation imposes information collection requirements as part of the reasonable procedures that an employee benefit plan must establish regarding the handling of a benefit claim. These requirements include third-party notice and disclosure requirements that the plan must satisfy by providing information to participants and beneficiaries of the plan.

A June 2011 amendment to the interim final regulations (75 FR 37208 (6/24/2011)), makes two revisions to the ICR. The first is an amendment no longer requiring plans to include diagnosis and treatment codes on notices of adverse benefit determination and final internal adverse benefit determination. Instead, they must notify claimants of the opportunity to receive the codes on request and plans and issuers must provide the codes upon request. The Departments expect that this change will lower costs, because plans and issuers no longer will have to provide the codes on the notices. Plans and issuers will incur a cost to establish procedures for receive, process, and mail the codes upon request; however, the Departments do not have sufficient data to estimate such cost due to a lack of a basis for an estimate of the number of requests that will be made for the codes.

The amendment also changes the method plans and issuers must use to determine who is eligible to receive a notice in a culturally and linguistically appropriate manner, and the information that must be provided to such persons. The previous rule was based on the number of employees at a firm. The new rule is based on whether a participant or beneficiary resides in a county where ten percent or more of the population residing in the county is literate only in the same non-English language. The impact of this change on cost burden associated with this ICR is discussed in Item 13, below under the heading "Non-English Language Assistance."

The Department is issuing final regulations that retain the information collections contained in the interim final regulations (and June 2011 amendment) without change.

2. *Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.*

   The information collection requirements included in the claims procedure regulation ensure that participants and beneficiaries (claimants) receive adequate information regarding the plan's claims procedures and the plan's handling of specific benefit claims. Participants and beneficiaries need to understand plan procedures and plan decisions in order to appropriately request benefits and/or appeal benefit denials.

3. *Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration for using information technology to reduce burden.*

   The claims regulation does not restrict plans' use of electronic technology to process and pay claims, to maintain information as to the basis for claim determination, and to generate correspondence related to claims processing decisions. This DOL claims procedure regulation also incorporates by reference pertinent provisions of the Department's separate regulation, 29 CFR 2520.104b-1, facilitating and encouraging the use of electronic information technology.

4. *Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.*

   No duplication with other Federal statutes exists. In some circumstances, states may require substantially similar information to be provided to insured persons. However, no duplication occurs because the same information disclosure may be used to satisfy duplicative or overlapping requirements.

5. *If the collection of information impacts small businesses or other small entities describe any methods used to minimize burden.*

   The regulation applies to all employee benefit plans and therefore is likely to affect small entities (small business, small plans) that provide benefits. The Department took into account the potential burden on small entities in structuring the regulation by permitting plan sponsors the maximum possible flexibility in designing their plans, including the possibility of hiring third-party service providers to carry out these administration

responsibilities in order to make use of the lowest cost method of compliance available. A large majority of small plans purchase claims administration services from insurers, HMOs, and other service providers, and the Department has taken this fact into account in deriving its burden estimates. These service providers typically develop a single claims processing system to service a large number of customers, including small entities. Thus, the infrastructure cost for this information collection is spread thinly over a large number of small plans. Moreover, small plans and their respective enrollees benefit equally from the service provider's expertise and ability to provide improved accuracy and timeliness in claims and appeals determinations.

6. *Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.*

The information collection requirements arise in connection with the occurrence of individual claims for benefits and consist of third-party notices and disclosures. No information is reported to the Federal government. Every claim event is normally of importance to the specific participant who relies on an employee benefit plan to provide the promised benefit. The information collection provisions of the regulation ensure that sufficient information is provided to: a) participants and beneficiaries so that they may fully exercise their rights under their employee benefit plans, and b) to fiduciaries responsible for operating plans in accordance with their terms.

7. *Explain any special circumstances that would cause an information collection to be conducted in a manner:*

- *requiring respondents to report information to the agency more often than quarterly;*
- *requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;*
- *requiring respondents to submit more than an original and two copies of any document;*
- *requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;*
- *in connection with a statistical survey, that is not designed to produce valid and reliable results that can be generalized to the universe of study;*

- *requiring the use of a statistical data classification that has not been reviewed and approved by OMB;*

- *that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or*

- *requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

The DOL claims procedure regulation imposes special timing requirements for the handling of claims under group health plans. Depending on circumstances indicating the urgency of the need for a claims decision, group health plans may be required to notify claimants about health benefit claim determinations in fewer than 30 days.

First, for claims involving "urgent care," the regulation requires, in general, that claimants be notified of health benefit determinations "as soon as possible, but not later than 72 hours after receipt of the claim by the plan..." 29 CFR 2560.503-1(f)(2)(ii).[2] In cases involving urgent care where the health claim is a request to extend the time period or number of treatments of ongoing medical care, this period is 24 hours. 29 CFR 2560.503-1(f)(2)(ii)(B).

Second, for "pre-service" claims, the regulation requires that claimants be notified of health benefit determinations "within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan." 29 CFR 2560.503-1(f)(2)(iii)(A). Pre-service claims involve plan requirements that a claimant obtain approval from the plan prior to receiving health care services or products in order to maintain eligibility for benefits.

Third, for "post-service" health benefit claims, the regulation requires notification of an adverse benefit determination "within a reasonable period of time, but not later than 30 days after receipt of the claim." Even though 30 days is the maximum response time for these claims, a plan must provide a determination sooner if it is reasonable to do so. Disability benefit claims are subject to a similar construct, except that the maximum response time is 45 days.

2 For non-grandfathered health plans and issuers offering group insurance coverage, the interim final regulations shortened the time period from 72 to 24 hours.

Appeals of denied claims must be decided within similar, short time limits.

These timing requirements are reasonably related to important policy objectives in an area of important public concern. For example, the shortest time frame for "urgent care" claims applies only under circumstances in which delay could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or where delay would subject the claimant to severe pain. The next shortest time frame applies under circumstances in which medical care, while not urgent, has not been provided to a claimant who needs treatment for a medical problem and where the plan itself requires pre-approval of the medical care before providing coverage. Post-service health claims and disability claims also involve important concerns relating to the sick and disabled, but under these circumstances plans may take at least 30 days to respond if it is reasonably necessary to do so.

Another reason why these time frames are important is that these notices relate to the payment of money by a plan to claimants to whom fiduciary responsibilities are owed. Without enforcement of reasonable deadlines, payors could be given a financial incentive to delay the payments, and this would likely be inconsistent with appropriate fiduciary standards.

8. *If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.*

   Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

   Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

   The interim final regulation (and the June 2011 amendment) provided the public with a

60-day period to submit written comments on ICRs contained therein. No comments were received.

9. *Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.*

DOL makes no payments to respondents.

10. *Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.*

This information collection request (ICR) involves disclosures of information by plan administrators to plan participants. Issues of confidentiality between third parties do not fall within the scope of this information collection request.

11. *Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.*

A plan provides information directly to the claimant. Sensitive issues, such as health information, would relate to the claim for which payment is sought, and the initial filing would have been initiated by the claimant or with the claimant's authorization.

12. *Provide estimates of the hour burden of the collection of information. The statement should:*

- *Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.*

- *If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13.*

- *Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 14.*

Because ERISA-covered plans already are required to comply with the DOL claims procedure regulation (OMB Control number 1210-0053), the Department did not attribute any cost for these plans to comply with this information collection. As stated above, paragraph (b)(2)(ii) provides additional standards non-grandfathered ERISA-covered plans must meet. The requirement to provide claimants, free of charge, any new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim,[3] and the requirement to comply either with a State external review process or a Federal review process increases the hour and cost burden imposed on plans and issuers to prepare and deliver the additional information to the claimant.

The burden associated with the additional standards that non-grandfathered ERISA-covered plans must meet is shared equally between the Department of Labor and the Department of the Treasury. The burden discussion below encompasses the combined burden of both agencies. A summary at the end describes the share of the burden allocated to the Department of Labor.

Ongoing burdens are a function of the number of external appeals filed as well as those requiring a fair and full review, which are in turn a function of health claims volume, as well as the denial and appeal rates.

Claims and Appeals

The transaction burden will vary widely with the type and complexity of claim in question, but the mix of claims and associated burdens generally are expected to be similar across plans of the same type. The average time required for this information

3 Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the plan or issuer can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

collection associated with any particular type of health benefit claim transaction will range from five minutes for a medical secretary to produce a notice for a fair and full review to as many as 20 minutes for a doctor to draft a response to an appeal brought before an external, independent review organization.

TABLE. 1--*Estimated Claims and Appeals in Non-grandfathered Coverage (in thousands)*

	2015	2016	2017
	Private Sector ESI	Private Sector ESI	Private Sector ESI
Total Enrollees	130,200	130,200	130,200
Non-Grandfathered Enrollees	96,348	96,348	96,348
Total Claims	982,750	982,750	982,750
Pre-Service			
Claim Approved	25,060	25,060	25,060
Claim Denied	4,422	4,422	4,422
Post-Service			
Claims Approved	774,815.5	774,815.5	774,815.5
Claim Denied	142,990	142,990	142,990
Claim Extended	35,462	35,462	35,462
Total Internal Appeals	337.2	337.2	337.2
Appeals Upheld	134.9	134.9	134.9
Appeals Denied	202.3	202.3	202.3
Medical subtotal	97.5	97.5	97.5
Appeals Upheld	39.0	39.0	39.0
Appeals Denied	58.5	58.5	58.5
Administrative subtotal	239.8	239.8	239.8
Appeals Upheld	95.9	95.9	95.9
Appeals Denied	143.9	143.9	143.9
Total New External Appeals	8.4	8.4	8.4

The Department estimates that approximately 93 percent of large benefit and all small benefit plans administer claims using a third-party provider, impacting approximately 95 percent of covered individuals. Therefore, approximately 5 percent of covered individuals will have their claims processed in-house. In-house administration burdens

are accounted for as hours and discussed in question 12, while purchased services and materials costs are accounted for as dollar costs and discussed in question 13. The hourly burden for plans processing claims in-house is described below:

TABLE 2.--*Hour Burden for Claims and Appeals (in thousands)*

	Annual
Fair and Full Review	1.0
Notice of Decision External Review	0.1
Total	**1.1**

Note: Assumed that 7 percent of large plan process these claims in-house in the Group Market. Large plans account for 69.5 percent of policy-holders and therefore 4.9 percent of claims are processed in-house.

The burden hours for claims and appeals are estimated at 1,000 hours annually at an equivalent cost of $52,000.

Federal External Review

As provided in the subregulatory guidance, the disclosure requirements of the Federal external review process requires (1) a preliminary review by plans of requests for external appeals; (2) Independent Review Organizations (IROs) to notify claimants of eligibility and acceptance for external review; (3) the plan or issuer to provide IROs with documentation and other information considered in making adverse benefit determination; (4) the IRO to forward to the plan or issuer any information submitted by the claimant; (5) plans to notify the claimant and IRO if it reverses its decision; (6) the IRO to notify the claimant and plan of the result of the final external appeal (burden previously accounted for); 7) the IRO to maintain records for six years.
The Departments estimate that there are approximately 78.7 million participants in self-insured ERISA-covered plans and approximately. In the States which currently have no external review laws or whose laws do not meet the federal minimum requirements[4] the Department estimates that there are approximately 8.1 million participants in ERISA-covered plans. These estimates lead to a total of 86.8 million participants, however, only the 64.2 million participants in non-grandfathered plans will be required to be covered by

4These states are Alabama, Alaska, Florida, Georgia, Pennsylvania, and Wisconsin. See Affordable Care Act: Working with States to Protect Consumers, available at https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html

the external review requirement.

The Departments estimate that there are an estimated 1.3 external appeals for every 10,000 participants,[5]and that there will be approximately 8,360 external appeals annually. Experience from North Carolina indicates that about 75 percent of requests for external appeals are actually eligible to proceed to an external review, therefore it is expected that there will be about 11,070 (8,630/0.75) requests for appeals.

The hour burden related to the preliminary review by plans of the request for external review is estimated to be 2,770 hours (11,070*0.25 hours) with an equivalent cost of $172,000 (2,770 hours * $62.22). It is estimated that it will require an average of 15 minutes for each of the requests, for a plan to make an eligibility determination. Plans will already have conducted internal reviews for eligible claimants; therefore, the required information for plans to make this determination should be readily available.

Once an eligibility determination is made, plans must provide the IRO with all documentation and other information considered in making an adverse benefit determination. For the 8,360 verified requests for external the hour burden is estimated as 700 hours (8,360* 5 minutes), with an equivalent cost of$21,180 (700* $30.42)

This leads to an hour burden of 3,470 hours with an equivalent cost of $193,700 related to external reviews.

Summary

In total, the burden associated with claims, appeals, and external review is approximately 4,500 hours at an equivalent cost of $244,800 annually. Because the burden is shared equally between the Department of Labor and the Department of the Treasury, the Department of Labor's share is 2,300 hours at an equivalent cost of $122,400 annually.

13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 or 14).

Claims and Appeals

As indicated in question 12, the bulk of these claims will be processed by third-party service providers. Total costs are estimated by multiplying the number of responses by

5 AHIP Center for Policy and Research, "An Update on State External Review Programs, 2006," July 2008.

the amount of time required to prepare the documents and then multiplying this by the appropriate hourly cost of either clerical workers ($30.42)[6,7] or doctors ($181.07),[8] and then adding the materials and postage costs of mailing responses ($0.59 each for those not sent electronically).[9] These costs are described below:

TABLE 3.--*Cost Burden for Claims and Appeals (in thousands)*

	Service Provider Labor Cost	Service Provider Mailing Cost	In-House Mailing Cost	Total Costs
Fair and Full Review	$561.2	$103.0	$5.3	$669.5
Notice of Decision External Review	$430.7	$4.7	$0.2	$435.6
Total Costs	**$991.9**	**$107.7**	**$5.5**	**$1,105.1**

The total estimated cost burden for those plans that use service providers, including the cost of mailing all responses (including mailing costs for those responses prepared in-house), is $1.1 million annually.

Non-English Language Assistance

As a result of the May 2011 amendment to the interim final regulations, plans and issuers must provide participants and beneficiaries who reside in a county where ten percent or more of the population residing in the county is literate only in the same non-English language with a one-sentence statement in all notices written in the applicable non-English language about the availability of language services. In addition to including the statement, plans and issuers are required to provide a customer assistance process (such

6 The Department's estimated 2015 hourly labor rates include wages, other benefits, and overhead are calculated as follows: mean wage from the 2013 National Occupational Employment Survey (April 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/pdf/ocwage.pdf); wages as a percent of total compensation from the Employer Cost for Employee Compensation (June 2014, Bureau of Labor Statistics http://www.bls.gov/news.release/ecec.t02.htm); overhead as a multiple of compensation is assumed to be 25 percent of total compensation for paraprofessionals, 20 percent of compensation for clerical, and 35 percent of compensation for professional; annual inflation assumed to be 2.3 percent annual growth of total labor cost since 2013 (Employment Costs Index data for private industry, September 2014 http://www.bls.gov/news.release/eci.nr0.htm).

7 Secretaries, Except Legal, Medical, and Executive (43-6014): $16.35(2013 BLS Wage rate)/0.675(ECEC ratio) *1.2(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $30.42

8 Family and General Practitioner (29-1062): $88.43(2013 BLS Wage rate) /0.69(ECEC ratio) *1.35(Overhead Load Factor) *1.023(Inflation rate) ^2(Inflated 2 years from base year) = $181.07

9 $0.49 for USPS First Class Postage and $0.05 per page of materials costs for two pages of paper.

as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

The Department understands that oral translation services are already provided for nearly all covered participants and beneficiaries. Therefore, no additional burden is associated with this requirement of the amendment.

The Department expects that the largest cost associated with the rules for culturally and linguistically appropriate notices will be for plans and issuers to provide notices in the applicable non-English language upon request. Based on the American Community Survey (ACS),[10] the Departments estimate that there are about 8.7 million individuals living in covered counties that are literate in a non-English Language. The ACS does not have insurance coverage information. Therefore, to estimate the percentage of the 8.7 million affected individuals that were insured, the Departments used the percent of the population in the state that reported being insured by private employer insurance from the 2014 CPS.[11] This results in an estimate of approximately 3.4 million individuals who are eligible to request translation services.

In discussions with the regulated community, the Departments found that experience in California, which has a state law requirement for providing translation services, indicates that requests for translations of written documents averages 0.098 requests per 1,000 members. While the California law is not identical, and the demographics for California do not match other counties, for purposes of this analysis, the Departments used this percentage to estimate of the number of translation service requests that plan and issuers can expect to receive. Industry experts also told the Departments that while the cost of translation services varies, $500 per document is a reasonable approximation of translation cost.

Using the ACS and the CPS, the Departments estimate that there are 20.8 million individuals insured through private employer sponsored insurance living in the affected counties. Based on the foregoing, the Departments estimate that the cost to provide translation services will be approximately $1 million annually (20,842,000 lives * 0.098/1000 * $500).

Federal External Review

10 Data are from the 2009-2013 American Community Survey available at www.census.gov/acs . Individuals counted reside in counties where at least 10 percent of the county speak a particular non-English language and speak English less than "very well" are counted.

11 Please note that using state estimates of insurance coverage could lead to an over estimate if those reporting in the ACS survey that they speak English less than "very well" are less likely to be insured than the state average.

The Department estimates that the Federal external review procedures will result in a cost burden of approximately $80,000 annually. The cost burden results from the cost associated with preparing and mailing required notices and documents. Plans must provide the IRO with all documentation and other information considered in making adverse benefit determinations for each of the 8,000 claimants eligible for external appeal. The Department estimates that this will cost, on average, $1.49 per claimant. IROs must also send each eligible claimant a notice of eligibility and acceptance, at an average cost of $0.54. IROs are required to send to plans all documents that claimants submit. The Departments do not know what fraction of claimants will submit additional documentation, but for purposes of this burden analysis assumes, that half of claimants (4,200) do. The Department assumes that the IRO has clerical staff with a labor rate of $30.42 that will spend, on average five minutes per claimant preparing and forwarding the required documents, and that IROs incur an average cost of $0.99 to mail the documents.

IROs also are required to maintain records of all claims and notices associated with the external review process for six years. The Departments believe that these documents would be retained as a customary part of business, but estimate that clerical staff will spend on average an additional five minutes per claimant ensuring all files are complete.

The Department is not able to estimate the number of reversals and the associated notices to claimants and IROs that plans would send due to reversing its prior decision, but believes the number would be small.

Summary

In total, the cost burden associated with claims, appeals, language translation, and external review is approximately $2.3 million annually. Because the burden is shared equally between the Department of Labor and the Department of the Treasury, the Department of Labor's share is $1.1 million annually.

14. *Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.*

There are no costs to the Federal government associated with this information collection.

15. *Explain the reasons for any program changes or adjustments reporting in Items 13 or 14.*

Because the final rule does not change the information collection requirements contained interim final regulations (and June 2011 amendment), most of the burden increase results from an increase in the number of non-grandfathered group health plans subject to the requirements of this information collection. A small portion also results from increases in wage rates and increases in postage rates.

16. *For collections of information whose results will be published, outline plans for tabulation, and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.*

Not applicable.

17. *If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.*

There are no forms on which to display the expiration date.

18. *Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission."*

Not applicable; no exceptions to the certification statement.

SUPPORTING STATEMENT B—STATISTICAL METHODS

This information collection does not employ statistical methods.